Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Administration on Aging's Health Care Fraud and Abuse Programs

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18-Month Outcomes

JUNE GIBBS BROWN
Inspector General

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To report on 18-month performance of the Administration on Aging's (AoA) two health care fraud and abuse control programs.

BACKGROUND

The AoA asked the Office of Inspector General (OIG) to assess the performance and implementation of its two health care fraud and abuse control programs: the Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program and the Health Insurance Portability and Accountability Act (HIPAA)-funded Program. AoA will use this information to inform Congress and others about the programs' performance and to develop guidance for current and future projects.

Both of these programs aim to educate beneficiaries about health care fraud, waste, and abuse, but operate somewhat differently. The community volunteer program receives $2 million and provides grants to 12 organizations to recruit and train retired professionals to conduct group sessions to educate beneficiaries. This program has recently been expanded to $7 million. The second program receives $1.4 million in funding under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The goal of this program is to train aging network staff and volunteers to educate Medicare beneficiaries about health care fraud, waste, and abuse as part of their ongoing activities.

In response to AoA's request, the OIG developed two reports. This report presents 18-month performance data for the two programs and a companion report entitled, *AoA's Health Care Fraud and Abuse Programs: Implementation Issues* OEI-02-99-00111, describes implementation issues and effective practices of the two programs. The findings in these reports are based on self-reported data that were not independently verified.

FINDINGS

The AoA's two anti-fraud programs educated thousands of beneficiaries who identified some instances of health care fraud, waste, and abuse.

In their first 18 months of operation, AoA's two anti-fraud programs trained a total of 13,700 aging network staff, volunteers, and retired seniors to be Medicare educators and resources. These trainers educated at least 71,460 Medicare beneficiaries about how to identify and report

suspected instances of health care fraud and abuse. Additionally, the two programs reported conducting 570 media events and 2,880 community education activities.

In total, the programs referred 871 allegations to Medicare contractors or other agencies for follow-up. These referrals generated 133 complaints that resulted in some action. The projects also reported that an estimated $1.24 million in Medicare funds and $102,000 in Medicaid and other funds may be recouped as a result of their efforts.

The two programs produced different results.

The community volunteer projects recruited and trained 3,700 individuals to educate beneficiaries. More than half were retired professionals. These trainers educated about 58,700 beneficiaries and family members in group sessions, teaching them how to identify and report health care fraud and abuse. They reached another 2,000 beneficiaries in one-on-one sessions. In total, five community volunteer projects reported a potential $1.24 million in Medicare savings.

The HIPAA-funded projects trained over 10,000 individuals who were primarily ombudsman staff and volunteers or health insurance counselors. These trainers were able to reach at least 10,000 beneficiaries. The HIPAA-funded projects did not specifically report data on the number of beneficiaries reached in one-on-one sessions. None of these projects could document any potential Medicare savings as of 18 months, partly because many of these projects did not track complaint outcomes.

CONCLUSION

Two outcome measures are particularly important for measuring the performance of these two programs: the number of beneficiaries educated and the amount of money saved by the programs.

Educating Beneficiaries: Both programs educated an impressive number of beneficiaries. The community volunteer program, however, appeared to reach a greater number of beneficiaries than the HIPAA-funded program. This difference was partly due to the different approaches that the two programs implemented. Specifically, the community volunteer program generally followed a train-the-trainer approach in which the trainers conducted group sessions, whereas the HIPAA-funded program trained existing network staff and volunteers who met with beneficiaries one-on-one, as part of their ongoing responsibilities.

Tracking Savings: Direct evidence about savings was difficult to obtain. While the programs were successful in educating beneficiaries, there was no direct evidence that they produced more savings than the amount of money that was invested in them. There are a number of reasons for this lack of evidence. First, beneficiaries are often encouraged to call their provider or Medicare contractor with problems and projects may not be aware of these activities. Second, the projects

are relatively new and not all of them have developed tracking systems for the complaints that come to their attention. Third, the investigative and prosecutorial processes are lengthy and therefore 18 months may not be enough time to achieve significant savings. Lastly, there is likely to be a sentinel effect from this initiative that is reducing inappropriate billing.

Additionally, we found that performance among the projects was very uneven. While many projects were successful in educating beneficiaries and in identifying some savings, almost an equal number produced minimal results during the first 18 months of the program.

Based on these findings, we encourage AoA to continue its work with the projects to identify and institutionalize effective practices. Further, as AoA expands the community volunteer program, it needs to assist new grantees so that they do not "reinvent the wheel" as they start-up their efforts. We hope that this report and our companion report will help AoA achieve these objectives and help new grantees, as well as current projects, implement effective practices and improve future performance.

COMMENTS

We received comments from AoA. They pointed out the difficulty in tracking specific dollar savings early in the program. However, they are optimistic that the thousands of trained beneficiaries will have a significant impact on fraud, waste, and abuse in the Medicare program. The full text of AoA's comments can be found in Appendix D.

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INTRODUCTION

PURPOSE

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BACKGROUND

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AoA asked OIG to evaluate the performance and the implementation of its anti-fraud initiatives for several reasons. First, this information is a continuation of other work conducted by the OIG. At AoA's request, the OIG helped develop performance measures for the community volunteer program and agreed to collect these data on an ongoing basis. Second, the results of the report that presented first year performance data entitled, *Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program: First Year Outcomes* OEI-02-97-00522, generated interest in implementation issues. This report found that first year performance varied widely among the 12 projects, suggesting that the projects implemented the program differently or that some had slower starts than others. Third, Congress recently expanded the community volunteer program and AoA is currently selecting new grantees. As a result of these factors, AoA believed that it was an important time to look at these issues.

To meet these objectives, the OIG developed two reports. The following report presents 18-month performance data for the two programs. A companion report entitled, *AoA's Health Care Fraud and Abuse Programs: Implementation Issues* OEI-02-99-00111, describes the implementation of these two programs including problems projects encountered and practices they developed to overcome these barriers.

Operation Restore Trust

In 1995, AoA became a partner in a OIG-led demonstration project to fight fraud, waste, and abuse in the Medicare and Medicaid programs called Operation Restore Trust (ORT). This two-year demonstration program focused on combating health care fraud, waste, and abuse in five States. This initiative showed that Medicare beneficiaries and others could play an important role

in curbing losses to the Medicare and Medicaid programs by becoming better educated about how to identify and report suspected instances of fraud and abuse. The results of the demonstration program encouraged AoA to continue and to expand its efforts.

Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program

Congress authorized the Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Demonstration Program in the Omnibus Consolidated Appropriation Act of 1997 (P.L. 104-208) to further reduce fraud and abuse in the Medicare and Medicaid programs. At that time, the Senate Committee believed that thousands of retired accountants, health professionals, investigators, teachers, and others could serve as community volunteers in this effort. More specifically, these retired professionals, with appropriate training, could serve as Medicare educators and as expert resources to assist Medicare beneficiaries and others to detect and report fraud, waste, and abuse. Because the language for this program was introduced by Senator Tom Harkin of Iowa, these grants are commonly known as "Harkin Projects." For this inspection, they are referred to as the community volunteer projects.

To fund this program, the Senate Report (104-368) directed that $2 million be transferred to AoA from the Health Care Financing Administration's research and demonstration budget. In July of 1997, AoA awarded grants to 12 organizations including two area agencies on aging, six State units on aging, and four private aging organizations. This report is based on these 12 projects.

As of October 1998, the program was expanded. Under Title IV of the Older Americans Act in the FY1999 Omnibus Appropriations Act, funding for the program was increased to $7 million, significantly extending the scope of the program. AoA is currently reviewing applications and selecting grantees for this new round of funding. These projects will be called the Senior Medicare Patrol Projects.

HIPAA-Funded Program

The AoA developed a second set of projects that are funded under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The goal of these projects is to combat health care fraud, waste, and abuse by training aging network staff and volunteers to educate Medicare beneficiaries. In August 1997, AoA awarded grants to 15 State units on aging. In March 1998, the program was expanded to include three additional States. The program received a total of $3.8 million for the first three fiscal years. In FY 99, $1.4 million in funding was provided. About $900,000 of these funds was granted to State units on aging. The remaining funds were used by AoA for training and technical assistance for the grantees, for facilitating the exchange of resources, for identifying best practices, for convening national and regional partnership conferences, and for developing and disseminating informational materials.

It is important to note that the two programs differ in several ways. First, the HIPAA-funded projects primarily train aging network staff and volunteers who educate Medicare beneficiaries as part of their ongoing activities. In contrast, the community volunteer projects recruit and train retired seniors who conduct group sessions to educate Medicare beneficiaries. Second, the HIPAA-funded projects are run solely by State agencies, whereas the community volunteer projects are operated by State, local, or non-profit agencies. Third, the HIPAA-funded projects receive less funding than the community volunteer projects. Specifically, AoA awarded $50,000 annually to HIPAA-funded projects and between $100,000 and $188,000 per year to community volunteer projects.

Performance Measures

With the assistance of AoA and the 12 projects, OIG developed a set of performance measures for the community volunteer projects. (See *Health Care Anti-Fraud Volunteer Project Performance Measures* OEI-02-97-00520.) To provide ongoing information about the program, the OIG asked each of the projects to provide data on these agreed upon performance measures on the 12, 18, 24, and 30 month anniversary of the initial grant. As mentioned earlier, first year outcomes are presented in the OIG report entitled, *Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program: First Year Outcomes* OEI-02-97-00522.

Westat, Inc. a private research corporation under contract with AoA, developed performance measures for the HIPAA-funded projects. Westat, Inc. collected preliminary outcome data for the first year and is currently conducting a longer-term evaluation of both fraud and abuse control programs. This evaluation will provide a more in-depth analysis of the implementation and impact of the two programs.

METHODOLOGY

This inspection was conducted in several phases. First, OIG staff collected performance data from the 12 community volunteer projects and 17 HIPAA-funded projects for the first 18 months of the programs. Appendix A provides a list of all projects. Note that the New York State Unit on Aging which receives funding from both programs is considered a community volunteer project for the purposes of this report.[1] Also, this report includes first year performance data for the three HIPAA-funded projects that received funding in the second year.

Community volunteer projects reported data for the measures developed by the OIG for the time period covering July 1, 1997 through December 31, 1998. The HIPAA-funded projects reported data for the measures developed by Westat, Inc. for August 1,1997 through January 31, 1999.

[1]Project staff explained that they use the community volunteer grant to fund several area agencies on aging to conduct anti-fraud activities and the HIPAA grant for administrative purposes.

The OIG staff reviewed these data for consistency and compared them to 12-month data when appropriate. Appendices B and C present the data reported by each project. In addition, we asked grantees to provide documentation about any money that was identified due to their project's efforts.

Second, we asked AoA for the projects' most recent semi-annual report that they submitted as part of AoA's reporting requirements. Whenever possible, we compared these reports to their performance data to check for consistency.

Third, we interviewed staff from each project. We conducted interviews with staff members from selected projects on-site and interviewed the others by telephone. We asked project staff about their experiences with implementing the program and about problems that they have had. We also asked them to identify practices that have been effective, particularly in tracking outcomes. The results of these data are reported in detail in our companion report entitled, *AoA's Health Care Fraud and Abuse Programs: Implementation Issues* OEI-02-99-00111.

As described, the two programs took different approaches to fighting health care fraud, waste, and abuse. The measures that the programs were asked to report also differ in several ways. For these reasons, we believe that a side-by-side comparison of the two programs is not appropriate. A separate analysis of each program is therefore presented.

Limitations

It is important to note that the findings in this report are based on self-reported data that were not independently verified. Furthermore, outcome findings gauge the extent to which the program is achieving its intended goals; they do not provide information about the quality of these outcomes nor the implementation of the program.

The following analysis does not solely focus on complaint outcomes for several reasons. As described below, projects tracked these outcomes to different degrees. The number of complaints that resulted in some action therefore may be an indication of a project's capacity to track, rather than its performance. Additionally, complaints may take a long time to investigate and therefore it may be too early to evaluate a project based on these measures.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

FINDINGS

The AoA's two anti-fraud programs educated thousands of beneficiaries who identified some instances of fraud and abuse.

In their first 18 months of operation, AoA's two anti-fraud programs trained a total of 13,700 aging network staff, volunteers, and retired seniors to be Medicare educators and resources. About 3,200 of these individuals, or 38 percent, went on to educate others or to conduct outreach activities about health care fraud, waste, and abuse.

Trainers in the two program educated at least 71,460 Medicare beneficiaries and family members. Typically, they conducted group sessions or met with beneficiaries one-on-one, instructing them how to review their health care bills, statements, and other documents, and how to identify and report any suspected instances of fraud and abuse. The two programs also reported conducting a total of 570 media events and 2,880 community education activities. These activities were generally aimed at informing the larger public about these issues.

In total, the programs referred 871 allegations to Medicare contractors or other agencies for follow-up. These referrals generated 133 complaints that resulted in some action. The projects also reported that an estimated $1.24 million in Medicare funds and $102,000 in Medicaid and other funds may be recouped as a result of their efforts. Not all projects were able to identify potential Medicare savings.

Several projects qualified the data they reported about complaints. A few stressed that their numbers underestimated the impact of the program. They explained that they sometimes encouraged beneficiaries to make complaints to their Medicare carrier or to the OIG Hotline directly. They did not, however, have the capacity to track complaints made through these channels. In addition, several projects noted that complaints often took a long time to investigate and therefore their outcomes may not be known at this time.

COMMUNITY VOLUNTEER PROJECTS

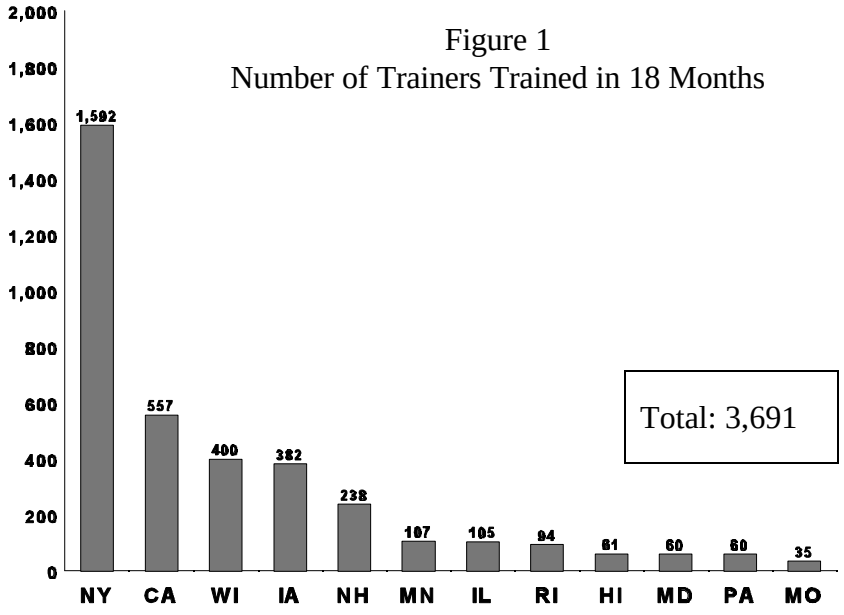
The community volunteer projects generally implemented a train-the-trainer approach. Projects typically recruited seniors at senior centers and in the community at large. They then trained them to conduct presentations or group sessions to educate Medicare beneficiaries. Additionally, most projects also trained aging network staff and volunteers who educated beneficiaries about fraud and abuse as part of their ongoing responsibilities. These individuals typically included State and local long-term care ombudsmen, health insurance counselors, and others who worked directly with seniors.

Training Trainers

The 12 projects recruited and trained many retired seniors to be Medicare educators and trainers.

Overall, the 12 community volunteer projects reported recruiting and training a total of 3,691 individuals, at least half of whom were retired professionals.[2] Projects employed different strategies to recruit individuals such as advertising in local newspapers and approaching members of existing senior organizations. As shown in Figure 1, the number of trainers varied greatly by project.

Figure 1
Number of Trainers Trained in 18 Months



Note: Each grantee does not necessarily serve the entire State. Source: OEI Survey, 1999

[2] Note that projects defined who they considered to be professional differently. Additionally, three projects did not track this type of information.

Not all seniors who were trained, however, continued to stay involved in the projects. Most projects maintained a smaller corps of active volunteers. Taking into account the projects that tracked this information, about half of all individuals trained by the community volunteer projects ever conducted activities to educate beneficiaries. This rate varied by project, indicating that some projects were less successful than others at getting trainers involved once they had completed training. Six projects, for example, retained less than one-quarter of trainers, whereas the remaining five projects were able to involve at least two-thirds of all those trained.

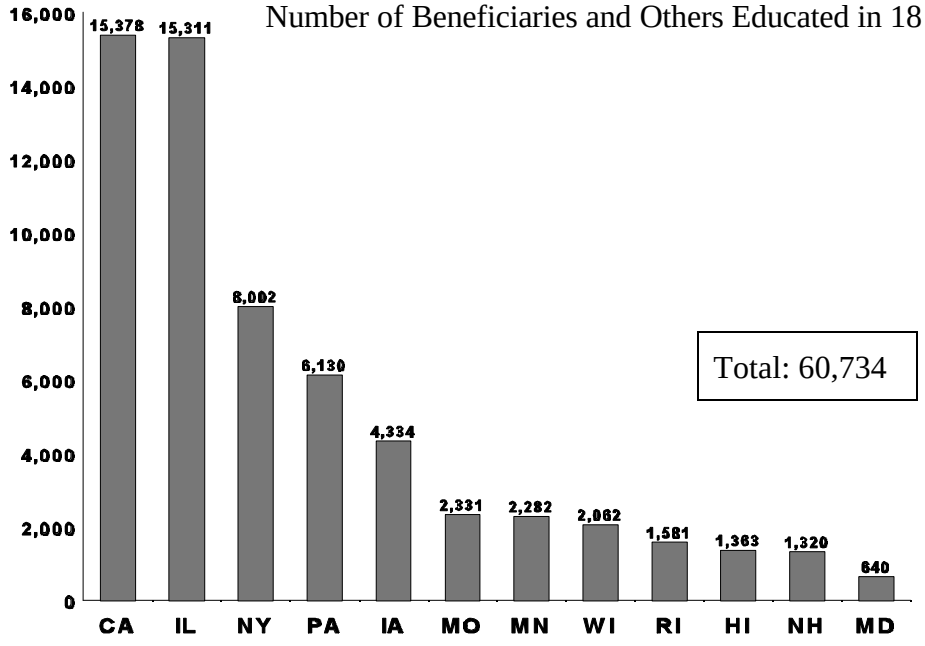
Educating Seniors

Projects educated a large number of beneficiaries and others to identify and report health care fraud, waste, and abuse.

Collectively, the 12 community volunteer projects reported educating about 60,734 beneficiaries, family members, and others in the first 18 months of the program. As shown in Figure 2, the number of beneficiaries educated varied by project.

The community volunteer projects typically conducted two types of training: group and one-on-one. In total, trainers led 1,422 group sessions that reached nearly 58,691 beneficiaries and others. All but two projects also conducted one-on-one sessions that reached another 2,043 individuals. Projects provided one-on-one assistance to varying degrees.

Figure 2
Number of Beneficiaries and Others Educated in 18 Months



Note: Each grantee does not necessarily serve the entire State.

Source: OEI Survey, 1999

There did not appear to be a strong relationship between the number of beneficiaries educated and the number of trainers in a project. Some projects that trained relatively few trainers were able to reach many beneficiaries. The project in Pennsylvania, for example, trained 60 individuals, 40 of whom ever conducted activities, and educated more than 6,000 beneficiaries. Similarly, some projects that trained large numbers of trainers reached relatively few beneficiaries. The project in New Hampshire, for example, trained 238 individuals, all of whom conducted some activities, but educated only 1,300 beneficiaries.

Community Awareness

Projects conducted various outreach activities, raising awareness about health care fraud and abuse.

The 12 projects reported conducting a total of 420 media events that reached an estimated 68.5 million people in the first 18 months of the program. The projects also performed about 1,200 community education activities that informed an estimated 168,850 individuals. Overall, projects conducted a median of 20 media events and 51 community education activities. Some projects placed more emphasis on these types of activities than others. The project in Minnesota, for example, conducted 223 media events. The projects in New York and Iowa each conducted about 300 community activities. In contrast, a few projects held less than 15 of these types of activities.

Identifying Referrals

The projects identified suspected instances of fraud, waste and abuse, some of which may result in recouped Medicare funds.

Overall, the projects referred about 400 allegations to appropriate authorities. The majority of these referrals came from two projects, Iowa and New York, which referred 171 and 52 allegations, respectively. Five other projects reported referring at least 20 complaints. One project did not make any referrals.

Projects reported that these referrals generated a total of 93 complaints that resulted in some action. Five projects also reported that an estimated $1.24 million in Medicare funds may be recouped as a result of their efforts. The other seven projects did not know or reported that none of the complaints they referred had resulted in Medicare funds being recouped. In addition, six projects estimated that $102,000 in Medicaid and other funds may be recouped due to their projects' efforts.

HIPAA-FUNDED PROJECTS

The HIPAA-funded projects implemented the program differently than the community volunteer projects. The HIPAA-funded projects primarily trained aging network staff and volunteers about fraud and abuse. These individuals typically met with Medicare beneficiaries and others one-on-one and integrated what they learned about fraud, waste, and abuse in their usual activities. In general, these projects placed less emphasis on conducting group sessions to educate Medicare beneficiaries compared to the community volunteer projects.

Training Trainers

The HIPAA-funded projects trained large numbers of staff and volunteers, primarily in the aging network

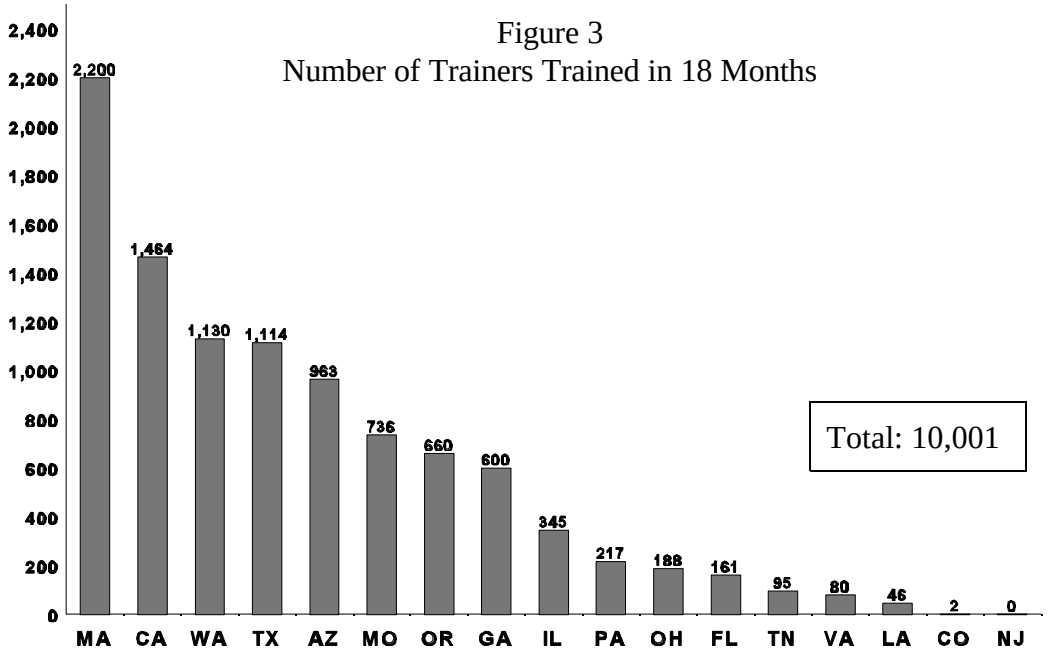
The 17 HIPAA-funded projects reported training a total of about 10,000 staff and volunteers to be Medicare resources and educators in the first 18 months of the program. As shown Figure 3, the number of individuals trained varied greatly by project. Unlike the community volunteer projects, it was not uncommon for these trainers to also educate additional staff and volunteers. Collectively, the projects reported conducting sessions to educate another 3,000 staff and volunteers about fraud and abuse.

The variation in the number of trainers reflects the different approaches taken by the projects. The project in Colorado, for example, trained a small number of staff and volunteers who trained additional staff and volunteers. In contrast, the project in Massachusetts, trained a large number of staff and volunteers who did not conduct any additional sessions to train others.

In all but one project, the majority of people trained were staff and volunteers in the aging network. These individuals typically included State and local long-term care ombudsmen, health insurance counselors, aging network service staff, and others who worked directly with older people. Only five projects reported training staff and volunteers who were not in the aging network. These individuals typically included senior advocates, retired seniors, and others.

Although projects trained a large number of staff and volunteers, not all remained active. Taking into account only the projects that tracked this information, an estimated 2,141 individuals, or 34 percent of all those trained, were promoting awareness and the reporting of health care fraud and abuse at the end of the 18-month reporting period. This rate greatly varied among the projects, indicating that some projects had greater difficulty retaining volunteers than others.

Figure 3
Number of Trainers Trained in 18 Months



Note: Data for LA, NJ, and OR include only the first year of the program.

Source: OEI Survey, 1999

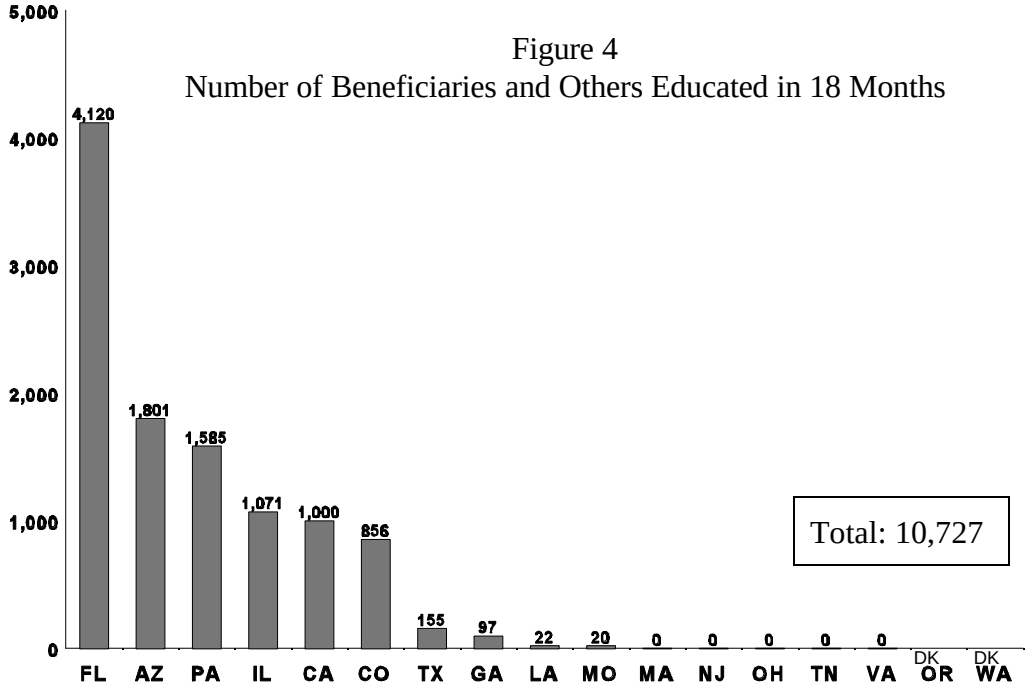
Educating Seniors

Several projects educated many Medicare beneficiaries and others.

The HIPAA-funded projects reported educating a total of about 10,700 Medicare beneficiaries, family members, caregivers, and others. As discussed, not all projects implemented the program in this way. Also, the HIPAA-funded projects were not asked to specifically report the number of one-on-one sessions that they conducted. Most likely, this information would have substantially increased the number of beneficiaries that were informed about fraud and abuse as a result of these projects.

Most projects reported conducting some sessions to educate beneficiaries and others about health care fraud and abuse. Six projects conducted at least 30 sessions each or informed more than 850 beneficiaries each in this manner. These projects appeared to be similar to the community volunteer projects. For example, the project in Florida which followed the train-the-trainer model, reached the largest number of beneficiaries, over 4,100, or about 38 percent of the total number educated by all projects.

Figure 4
Number of Beneficiaries and Others Educated in 18 Months



Note: Data may not include beneficiaries educated in one-on-one sessions.
Data for LA, NJ, and OR include only the first year of the program.
DK indicates grantee was unable to provide specific information.

Source: OEI Survey, 1999

Community Awareness

The HIPAA-funded projects also conducted public awareness campaigns and other community outreach activities to reach a broader audience.

HIPAA-funded projects reported conducting about 1,672 community education activities that informed more than 26,873 individuals about how to identify and report health care fraud and abuse. The number of outreach activities conducted varied by project. Specifically, seven projects conducted less than six presentations or other outreach activities each. Two projects organized more than 320 of these types of activities each.

The projects also developed a total of 152 public service announcements, press releases, or other media events. In addition, all of the projects developed several types of other outreach materials that most distributed widely. Collectively, the projects produced 155 brochures, posters, videos, public information documents, and training and other outreach materials. Projects distributed about 192,200 copies of these materials to members in their respective communities.

Identifying Referrals

Projects identified some instances of suspected fraud and abuse, although their outcomes are generally unknown.

The HIPAA-funded projects reported receiving a total of 2,586 calls concerning health care fraud and abuse, during the 18-month reporting period. They also reported referring 469 allegations to other agencies, forwarding almost half of them to Medicare contractors including carriers, intermediaries, or regional durable medical equipment carriers. They referred another 20 percent of the allegations to the OIG Hotline. The remaining complaints were sent to other health care programs such as insurance counseling agencies, State Medicaid Fraud Control Units, State Attorney General's Offices, or other fraud and abuse agencies.

Few HIPAA-funded projects tracked the outcomes of these complaints. Seven projects reported that a total of 22 complaints were accepted for investigation by complaint-handling agencies. None of the projects documented that any complaints resulted in money being recouped or in a conviction or other punitive action, although it may be too early to know this information. Two projects reported that 40 complaints resulted in some other type of action.

It is important to note that the HIPAA-funded projects were not required to track complaint outcomes. A few projects stressed that their role was to educate beneficiaries about how to detect and report fraud and abuse. They believed the tracking and investigation was best left to investigative agencies such as the Medicare contractors, the OIG, and State Attorney General's Offices. In addition, a few projects noted that they had not received any feedback about complaints that they forwarded to the OIG Hotline.

PERFORMANCE MEASURES

Performance measures are viewed as too complex.

Performance measures for the two grant programs were developed separately and take somewhat different approaches. Project staff had mixed reactions to the performance measures. They most commonly stressed the need for simplified, well-defined measures that were not too burdensome to complete.

The community volunteer projects were generally positive about the measures. A few commented that it is somewhat difficult to gather the information, particularly the amount of money recouped as a result of their project. They also noted that volunteers and AAA staff are often overworked and should not be overburdened with excessive paperwork. A few grantees specifically noted that it is very difficult, and perhaps unnecessary, to divide outcomes by retired professionals and others. Several projects also suggested that if it is mandatory to collect these measures then they should be part of AoA's reporting requirements.

The HIPAA-funded projects had additional comments about their performance measures. Several expressed that they were too detailed or cumbersome. One project suggested eliminating some of the questions, noting that "the easier the form, the more complete it will be." A few reacted more strongly, stating that the measures did not fit what their project was doing. As one grantee argued, "there is a large gap between the reality of what we are doing and what is being reported." Others stressed that they do not track outcomes nor do they have the capacity to divide their data into the required categories. Several projects had some difficulty distinguishing between the categories and suggested clarifying key definitions.

CONCLUSION

Two outcome measures are particularly important for measuring the performance of these two programs: the number of beneficiaries educated and the amount of money saved by the programs.

Educating Beneficiaries: Both programs educated an impressive number of beneficiaries. The community volunteer program, however, appeared to reach a greater number of beneficiaries than the HIPAA-funded program. This difference was partly due to the different approaches that the two programs implemented. Specifically, the community volunteer program generally followed a train-the-trainer approach in which the trainers conducted group sessions, whereas the HIPAA-funded program trained existing network staff and volunteers who met with beneficiaries one-on-one, as part of their ongoing responsibilities.

Tracking Savings: Direct evidence about savings was difficult to obtain. While the programs were successful in educating beneficiaries, there was no direct evidence that they produced more savings than the amount of money that was invested in them. There are a number of reasons for this lack of evidence. First, beneficiaries are often encouraged to call their provider or Medicare contractor with problems and projects may not be aware of these activities. Second, the projects are relatively new and not all of them have developed tracking systems for the complaints that come to their attention. Third, the investigative and prosecutorial processes are lengthy and therefore 18 months may not be enough time to achieve significant savings. Lastly, there is likely to be a sentinel effect from this initiative that is reducing inappropriate billing.

Additionally, we found that performance among the projects was very uneven. While many projects were successful in educating beneficiaries and in identifying some savings, almost an equal number produced minimal results during the first 18 months of the program.

Based on these findings, we encourage AoA to continue its work with the projects to identify and institutionalize effective practices. Further, as AoA expands the community volunteer program, it needs to assist new grantees so that they do not "reinvent the wheel" as they start-up their efforts. We hope that this report and our companion report will help AoA achieve these objectives and help new grantees, as well as current projects, implement effective practices and improve future performance.

COMMENTS

We received comments from AoA. They pointed out the difficulty in tracking specific dollar savings early in the program. However, they are optimistic that the thousands of trained beneficiaries will have a significant impact on fraud, waste, and abuse in the Medicare program. The full text of AoA's comments can be found in Appendix D.

APPENDIX A

The Health Care Fraud and Abuse Programs

Community Volunteer Projects

State Units on Aging
Hawaii
Iowa
Maryland
Minnesota
New Hampshire
New York*

Area Agencies on Aging
District III AAA, Missouri
Suburban AAA, Illinois

Private Aging Organizations
Aging 2000, Rhode Island
California Health Insurance Counseling Advocacy Programs
Coalition of Advocates for the Rights of the Infirm Elderly, Pennsylvania
Coalition of Wisconsin Aging Groups

HIPAA-Funded Projects

State Units on Aging
Arizona
California
Colorado
Florida
Georgia
Illinois
Louisiana+
Massachusetts
Missouri
New Jersey+
New York*
Ohio
Oregon+
Pennsylvania
Tennessee
Texas
Virginia
Washington

* Note: The New York State Unit on Aging receives both types of grants. For the purposes of this report, it is considered a community volunteer project.

+ Note: Incorporated at a later date and have only received funding for the second year.

APPENDIX B

18-Month Outcomes Reported by the Community Volunteer Projects

State	RI	IL	PA	MD	CA	MO	MN	IA	HI	WI	NY	NH	TOTAL
Projects	Aging 2000	Sub.AAA	CARIE	MD SUA	CHA	Dist 3 AAA	MN SUA	IA SUA	HI SUA	CWAG	NY SUA	NH SUA	
$ recruiting retired prof	20,000	35,445	20,200	*0*	7,447	19,692	30,818	*0*	12,693	*0*	12,870	12,663	171,828
$ recruiting others	0	12,510	2,050	9,000	25,000	7,816	2,694	37,779	0	16,000	19,454	2,533	134,836
$ training retired prof	40,000	45,870	30,000	*0*	57,344	22,225	8,245	*0*	38,078	*0*	10,329	37,990	290,081
$ training others	34,362	14,595	10,000	2,380	15,000	6,821	11,369	5,941	0	19,100	23,968	6,332	149,868
$ support retired prof	26,030	39,615	10,000	*0*	12,460	20,688	11,276	*0*	4,847	*0*	6,505	18,990	150,411
$ support others	2,000	16,680	5,000	2,500	30,810	5,713	8,531	38,912	0	29,400	3,360	6,332	149,238
$ community education	62,392	22,935	10,000	9,000	17,130	18,896	52,775	0	9,680	DK	54,581	37,990	295,379
$ tracking system	19,000	20,850	15,000	3,750	22,140	3,833	2,828	675	0	1,650	1,307	3,799	94,832
total $ spent	203,784	208,500	102,250	26,630	187,331	105,684	128,536	83,307	65,298	66,150	132,374	126,629	1,436,473
# training sessions	4	7	15	1	24	9	15	15	6	14	DK	3	113
# retired prof trained	23	85	50	*0*	483	31	28	*0*	42	0	941	215	1,898
# of others trained	71	20	10	60	74	4	79	382	19	400	651	23	1,793
total # of people trained	94	105	60	60	557	35	107	382	61	400	1,592	238	3,691
# media events	7	28	20	27	39	24	223	DK	20	3	17	12	420
# community ed. activities	14	46	100	187	0	48	53	334	11	79	297	40	1,209

Note: DK indicates grantees were unable to provide specific data.

APPENDIX B

18-Month Outcomes for the Community Volunteer Projects

State	RI	IL	PA	MD	CA	MO	MN	IA	HI	WI	NY	NH	TOTAL
Projects	Aging 2000	Sub.AAA	CARIE	MD SUA	CHA	Dist 3 AAA	MN SUA	IA SUA	HI SUA	CWAG	NY SUA	NH SUA	
# trainers who did activities	23	105	40	10	505	35	23	30	5	40	DK	238	1,054
# group sessions by prof	67	329	125	*0*	100	13	39	*0*	15	*0*	104	1	793
# group sessions by others	20	21	25	23	104	40	43	156	25	67	70	35	629
total # sessions	87	350	150	23	204	53	82	156	40	67	174	36	1,422
# of benes at ses. by prof	1,372	14,857	5,000	*0*	7,417	346	804	*0*	292	*0*	4,006	1,200	35,294
# of benes at ses. by others	209	340	1,000	368	7,715	1,439	1,460	4,259	1,071	2,027	3,409	100	23,397
total # of benes at ses.	1,581	15,197	6,000	368	15,132	1,785	2,264	4,259	1,363	2,027	7,415	1,300	58,691
# of 1-on-1 by retired prof	0	114	100	*0*	185	319	3	*0*	0	*0*	350	15	1,086
# of 1-on-1 by others	0	0	30	272	61	227	15	75	0	35	237	5	957
total of 1-on-1	0	114	130	272	246	546	18	75	0	35	587	20	2,043
total of benes educated	1,581	15,311	6,130	640	15,378	2,331	2,282	4,334	1,363	2,062	8,002	1,320	60,734
est. # of people by media hits	1,648,400	2,256,796	2,000,000	100,000	1,750,000	50,000	119,950	59,350,299	54,300	100,500	360,200	750,000	68,540,445
est # of people by com ed.	3,440	4,583	3,000	8,000	0	50,000	7,353	12,726	446	11,179	66,118	2,000	168,845
# complaints received	14	114	50	116	185	9	13	298	1	25	52	162	1,039
# complaints referred	14	26	35	29	24	7	2	171	0	16	52	26	402
# complaints resulted in action	DK	DK	10	29	4	0	0	12	0	10	23	5	93
Medicare $ recouped	DK	DK	74,124	DK	22,000	0	0	1,138,534	0	1,972	2,999	0	1,239,628
Other $ recouped	DK	DK	DK	DK	210	87,094	12,110	658	0	1,865	DK	100	102,036
Total $ recouped	DK	DK	74,124	DK	22,210	87,094	12,110	1,139,192	0	3,836	2,999	100	1,341,665

Note: DK indicates grantees were unable to provide specific data.

APPENDIX B

Community Volunteer Projects: Definitions

RETIRED PROFESSIONAL	These are retired individuals who were professionals (*e.g.,* teachers, lawyers, doctors, or accountants), who are new volunteers to the aging network, and who are trained to help beneficiaries identify Medicare fraud.
OTHERS	These are any other individuals who are trained to help beneficiaries identify Medicare fraud.
RECRUITING	Any effort to get individuals to take the training to become a trainer.
TRAINING	The process of training the trainer.
SUPPORT	Any activity to help the trainers, such as transportation, renting space, printing material, and telecommunications.
COMMUNITY EDUCATION	Any training, outreach, or education activity not directed at the trainers nor specifically in support of the trainers. It is geared to a broad audience.
TRACKING SYSTEM	The process of receiving, referring, and monitoring complaints.
TRAINED	Completed training to conduct beneficiary education.

APPENDIX B

Definitions (continued)

MEDIA EVENTS	Any individual airing or publishing of media (*e.g.*, print, radio, television, or electronic) to educate beneficiaries and their families about Medicare fraud. (If it is geared to trainers it is recruiting.)
COMMUNITY EDUCATION ACTIVITIES	Any beneficiary education activity not given by trainers or counted as media events.
BENEFICIARIES	Includes beneficiaries, family members, caregivers, and others who attended sessions.
GROUP SESSIONS	Medicare fraud education sessions for beneficiaries, family members, caregivers, and others led by trainers.
ONE-ON-ONE ENCOUNTER	Sessions led by trainers for an individual beneficiary and/or his or her family.
COMPLAINTS	Allegations of health care fraud and abuse reported by any individual as a result of the project's efforts.

Definitions (continued)

APPENDIX B

COMPLAINTS REFERRED FOR ACTION	Complaints deemed worthy of referring to a Medicare contractor or an investigative agency.
COMPLAINTS THAT RESULTED IN SOME ACTION	Referrals successfully closed by a Medicare contractor or an investigative agency (*e.g.*, conviction, judgement, plea, or overpayment).
MEDICARE $ RECOUPED	Funds returned to the Medicare Trust Fund.

APPENDIX C

18-Month Outcomes Reported by the HIPAA-Funded Projects

Activity	AZ	CA	CO	FL	GA	IL	LA	MA	MO	NJ	NY	OH	OR	PA	TN	TX	VA	WA	TOTAL
I. Training, Education, and																			
A. Materials development																			
1. # of brochures, posters, media products, or other public information documents	3	4	4	1	2	2	2	2	1	0	33	9	2	3	1	6	5	3	50
2. # of videos	2	0	0	1	0	0	0	0	0	0	5	1	1	0	0	DK	3	2	10
3. # of training curricula, manuals, handouts, or related instructional material	2	3	2	4	2	3	1	5	2	25	35	DK	2	3	0	2	2	1	59
4. # of other training, education, and outreach materials	2	12	4	2	1	DK	3	0	0	0	5	5	2	DK	2	DK	2	1	36
Total	9	19	10	8	5	5	6	7	3	25	78	15	7	6	3	8	12	7	155
B. Training and public information																			
1. # of training sessions for network on aging agency staff, volunteers, and others	56	8	2	9	11	10	3	20	15	0	275	3	7	5	3	15	1	35	203
2. # of network on aging staff and volunteers trained	875	350	2	130	600	345	46	2,200	736	0	1,397	188	660	217	95	654	80	1,130	8,308
3. # of other staff and volunteers trained	88	1,114	0	31	0	0	0	0	0	0	100	0	DK	DK	0	460	0	DK	1,693
4. # of forums and other public information presentations conducted (not in 1-3)	81	701	25	70	2	2	2	5	0	12	137	37	3	5	32	24	37	86	1,124

Note: The total does not include New York.

5. # of persons attending these forums and other public information presentations	**2,081**	**2,000**	**DK**	**5,257**	**65**	**12**	**100**	**300**	**0**	**1,500**	**10,125**	**4,200**	**160**	**228**	**1,422**	**1,007**	**5,168**	**3,373**	**26,873**
6. # of media events conducted	**9**	**0**	**2**	**76**	**7**	**2**	**1**	**0**	**0**	**0**	**69**	**0**	**3**	**6**	**3**	**10**	**0**	**33**	**152**
7. # of public information items distributed (# of copies)	**45,156**	**14,000**	**1,750**	**15,582**	**800**	**1**	**1**	**500**	**2,000**	**0**	**DK**	**19,113**	**10,000**	**15,000**	**5,428**	**DK**	**12,888**	**50,000**	**192,219**
8. # of other training, education, and outreach activities	**86**	**0**	**300**	**79**	**26**	**1**	**2**	**0**	**2**	**0**	**224**	**0**	**0**	**DK**	**0**	**26**	**50**	**1**	**548**

Note: The total does not include New York.

APPENDIX C

Activity	AZ	CA	CO	FL	GA	IL	LA	MA	MO	NJ	NY	OH	OR	PA	TN	TX	VA	WA	TOTAL
C. Activities of ORT trainees																			
1. # of ORT trainees currently promoting awareness and reporting of health care fraud and abuse	**96**	**1,112**	**DK**	**60**	**4**	**0**	**16**	**400**	**89**	**0**	**6,932**	**165**	**DK**	**DK**	**63**	**56**	**80**	**DK**	**2,141**
2. # of education and training sessions by ORT trainees for staff and volunteers	**58**	**7**	**15**	**0**	**0**	***2***	**6**	**0**	**0**	**0**	**240**	**0**	**9**	**5**	**3**	**3**	**0**	**DK**	**108**
3. # of staff and volunteers attending these sessions	**128**	**1,400**	**450**	**0**	**0**	**43**	**58**	**0**	**0**	**0**	**5,670**	**0**	**DK**	**560**	**285**	**68**	**0**	**DK**	**2,992**
4. # of sessions by trainees for beneficiaries, family members, care givers, and others	**75**	**DK**	**30**	**52**	**3**	**45**	**1**	**0**	**1**	**0**	**758**	**0**	**DK**	**40**	**0**	**4**	**0**	**DK**	**251**
5. # of beneficiaries, family members, care givers, and others attending these sessions	**1,801**	**1,000**	**856**	**4,120**	**97**	**1,071**	**22**	**0**	**20**	**0**	**9,184**	**0**	**DK**	**1,585**	**0**	**155**	**0**	**DK**	**10,727**
II. Health Care Fraud and Abuse Complaint Receipt and Referral																			
A. Types of calls received																			
1. # of calls concerning billing for services not received	**6**	**DK**	**DK**	**DK**	***2***	**DK**	**0**	**DK**	**0**	**0**	**31**	**DK**	**DK**	**DK**	**0**	**DK**	**7**	**10**	**25**
2. # concerning double billing	**3**	**DK**	**DK**	**DK**	**DK**	**DK**	**0**	**DK**	**0**	**0**	**48**	**DK**	**1**	**DK**	**0**	**DK**	**11**	**DK**	**15**
3. # concerning suppliers compiling CMN for physician	**0**	**DK**	**DK**	**DK**	**DK**	**DK**	**0**	**DK**	**0**	**0**	**0**	**DK**	**DK**	**DK**	**0**	**DK**	**0**	**DK**	**0**
4. # concerning services not needed	**2**	**DK**	**DK**	**DK**	***2***	***2***	**0**	**DK**	**0**	**0**	**131**	**DK**	**1**	**DK**	**0**	**DK**	**4**	**DK**	**11**

Note: The total does not include New York.

5. # concerning poor quality of care or limitations in needed care	**7**	**DK**	**DK**	**DK**	**DK**	**3**	**0**	**DK**	**0**	**DK**	**111**	**DK**	**DK**	**DK**	**0**	**DK**	**8**	**1**	**19**
6. # concerning other health care fraud and abuse	**6**	**DK**	**DK**	**DK**	**3**	**1**	**0**	**DK**	**0**	**0**	**0**	**3**	**1**	**DK**	**0**	**DK**	**5**	**6**	**25**
7. # concerning other health-related matters	**3,653**	**DK**	**DK**	**DK**	**DK**	***2***	**0**	**DK**	**0**	**DK**	**160**	**3**	**DK**	**8**	**0**	**DK**	**10**	**26**	**3,702**
8. # concerning non-health issues	**0**	**DK**	**DK**	**DK**	**DK**	**DK**	**0**	**0**	**0**	**DK**	**20**	**22**	**DK**	**DK**	**0**	**DK**	**8**	**DK**	**30**
Total	**3,671**	**DK**	**DK**	**43**	**7**	**8**	**0**	**2,302**	**0**	**0**	**501**	**28**	**3**	**8**	**0**	**152**	**53**	**43**	**6,318**

Note: The total does not include New York.

APPENDIX C

Activity	AZ	CA	CO	FL	GA	IL	LA	MA	MO	NJ	NY	OH	OR	PA	TN	TX	VA	WA	TOTAL
B. Complaints referred for action																			
1. # referred to the HHS TIPS Hotline	**26**	**6**	**DK**	**19**	**4**	**DK**	**6**	**DK**	**0**	**0**	**0**	**DK**	**DK**	**DK**	**0**	**29**	**DK**	**1**	**91**
2. # referred to the Medicare Carrier	**3**	**123**	**DK**	**21**	**DK**	**5**	**0**	**DK**	**0**	**5**	**52**	***2***	**2**	**4**	**0**	**DK**	**15**	**3**	**183**
3. # referred to the Fiscal Intermediary	**2**	**DK**	**DK**	**14**	**DK**	**DK**	**0**	**DK**	**0**	**0**	**0**	**DK**	**DK**	**DK**	**0**	**DK**	**12**	**DK**	**28**
4. # referred to the Regional DME Carrier	**1**	**DK**	**DK**	**0**	**DK**	**DK**	**0**	**DK**	**0**	**3**	**DK**	**1**	**1**	**DK**	**0**	**DK**	**7**	**DK**	**13**
5. # referred to the State Medicaid Fraud Control Unit/ Attorney General's office	**0**	**51**	**DK**	**5**	**DK**	**DK**	**0**	**DK**	**0**	**0**	**DK**	**1**	**DK**	**DK**	**0**	**DK**	**11**	**DK**	**68**
6. # referred to other fraud and abuse agencies	**2**	**DK**	**DK**	***2***	***3***	**1**	**0**	**DK**	**0**	**0**	**DK**	**DK**	**DK**	**DK**	**0**	**DK**	**7**	**DK**	**15**
7. # referred to other health care agencies	**0**	***26***	**DK**	**11**	**DK**	**2**	**0**	**DK**	**0**	**DK**	**DK**	**24**	**DK**	**DK**	**0**	**DK**	**8**	**DK**	**71**
8. # referred to the Eldercare Locator	**0**	**DK**	**DK**	**0**	**DK**	**DK**	**0**	**DK**	**0**	**0**	**0**	**DK**	**DK**	**DK**	**0**	**DK**	**0**	**DK**	**0**
Total	**34**	**206**	**DK**	**72**	**7**	**8**	**6**	**DK**	**0**	**8**	**52**	**28**	**3**	**4**	**0**	**29**	**60**	**4**	**469**
C. Complaint outcomes																			
1. # of referrals accepted for investigation by complaint-handling agencies	***8***	**DK**	**DK**	**1**	**7**	**1**	**DK**	**DK**	**0**	**0**	**11**	**1**	**DK**	**DK**	**0**	**1**	**DK**	**3**	**22**
2. # of convictions or other punitive actions	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**0**	**0**	**0**	**DK**	**DK**	**DK**	**0**	**0**	**DK**	**DK**	**0**
3. Dollar amounts recouped (including fines and restitutions)	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**0**	**0**	**3,000**	**DK**	**DK**	**DK**	**0**	**0**	**DK**	**DK**	**0**
4. # of other actions	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**DK**	**0**	**0**	**22**	**DK**	**DK**	**DK**	**0**	**39**	**DK**	**1**	**40**

Note: The total does not include New York.

APPENDIX C

Activity	AZ	CA	CO	FL	GA	IL	LA	MA	MO	NJ	NY	OH	OR	PA	TN	TX	VA	WA	TOTAL
III. Building Partnerships																			
A. Contacts with agencies and organizations concerning the design and operation of ORT																			
1. # of contacts with the Medicare Carrier	84	5	14	14	20	1	2	12	5	1	81	4	0	12	10	2	33	DK	219
2. # with the Financial Intermediary	27	DK	0	4	25	1	0	5	5	1	12	4	0	4	DK	2	21	0	99
3. # with the Regional DME Carrier	18	DK	0	2	2	1	0	9	1	1	67	5	0	4	10	2	10	4	69
4. # with the State Medicaid Fraud Control Unit/Attorney General's office	21	4	1	15	8	5	2	5	3	1	78	1	10	4	2	2	21	30	135
5. # with the State insurance counseling	DK	DK	0	58	10	7	2	DK	17	DK	2	20	10	DK	2	DK	29	DK	155
6. # with the LTC Ombudsman program	DK	DK	2	17	DK	2	1	10	DK	DK	0	17	10	DK	5	DK	79	20	163
7. # with other agencies/organizations	34	33	5	25	12	6	2	13	3	DK	93	6	10	12	30	DK	74	150	415
Total	184	42	22	135	77	23	9	54	34	4	333	57	40	36	59	8	267	204	1,255
B. Results of partnership-building activities																			
1. # of training materials these agencies and organizations helped develop	6	8	2	1	5	1	2	0	0	0	71	1	5	3	2	2	3	4	45
2. # of training sessions in which they participated as trainers	21	4	20	4	2	2	2	0	14	0	55	1	DK	5	5	1	1	35	117
3. # of ORT task force or other meetings in which they participated	39	8	13	30	10	2	0	0	3	0	30	1	10	4	3	3	3	20	149
4. # of written procedures developed with them to coordinate ORT activities	10	4	5	0	1	1	0	1	0	0	25	3	0	1	1	1	0	11	39
Total	76	24	40	35	18	6	4	1	17	0	181	6	15	13	11	7	7	70	350

Note: The total does not include New York.

APPENDIX C

Activity	AZ	CA	CO	FL	GA	IL	LA	MA	MO	NJ	NY	OH	OR	PA	TN	TX	VA	WA	TOTAL
IV. Staffing and Management																			
A. Uses of ORT funds																			
1.. # of SUA staff supported in whole or in part with ORT funds	6	0	1	2	1	0	0	0.5	0	0	0.75	2	0	0	1	0	0	0.17	14
2. # of AAA staff supported in whole or in part with ORT funds	0	0	0	5	0	0	DK	0	0	0	3	DK	0	0	0	0	0	0	5
3. # of other agency/organization staff supported in whole or in part with ORT funds	2	3	2	0	0	1	DK	0	1	0	1	DK	1	1	2	0	3	0	16
Total	8	3	3	7	1	1	0	1	1	0	4	2	1	1	3	0	3	0	35
B. Leveraging of ORT resources																			
1. # of network on aging staff supporting the ORT program who are paid for with other funds	24	99	1	17	30	13	1	19	1	5	27	12	0	30	0	54	0	34	340
2. # of volunteers supporting the ORT program	88	1,400	3	65	0	DK	46	400	0	400	1,500	DK	42	58	0	1,123	0	395	4,020
Total	112	1,499	4	82	30	13	47	419	1	405	1,527	12	42	88	0	1,177	0	429	4,360

Note: The total does not include New York.

APPENDIX C

Operation Restore Trust Program Performance Report
Instructions and Definitions

Training and public information activities: Section I A and B of the report cover the initial materials development and train-the-trainer sessions conducted by or on behalf of the ORT grantee. Trainees consist of the network on aging and other staff and volunteers, including personnel from State and Area Agencies on Aging and service providers, and staff and volunteers from the Long Term Care Ombudsman and insurance counseling programs, among others. These activities also include other outreach and informational efforts, such as presentations to professional groups and public service announcements (PSAs) to inform the public about ORT and how to identify and report cases of health care fraud and abuse. A major purpose of the ORT training activities described in Section I B is to create a cadre of knowledgeable individuals who, in turn, educate beneficiaries and others who work with them to identify and refer potential cases of health care fraud and abuse to appropriate federal or state agencies.

Activities of ORT trainees: Section I C covers the activities of these trainees after they return to their respective agencies and organizations. In many respects, this subsequent activity is the most important contributor to ORT success by promoting beneficiary awareness and reporting of fraud and abuse in the Medicare and Medicaid programs. Reporting this information, however, requires the grantee to establish and maintain ongoing communication with trainees on ORT activities.

Complaint receipt and referral activity: While the activities in this section are voluntary, AoA is encouraging all HIPAA grantees to build on or develop a state-level capacity to receive and screen calls about potential cases of health care fraud and abuse from Medicare and Medicaid beneficiaries, their family members or care givers, and others. Receiving these calls at the state level will allow screening for, and directly addressing, simple billing questions or other non-fraud and abuse cases that the state insurance counseling programs routinely handle.

This also permits referral of the remaining calls to the most appropriate fraud and abuse agency, including the new HHS TIPS Hotline number for use by the ORT grantees. Section II covers the receipt of these calls, the referral of these calls to the particular fraud and abuse agency, and the results or outcomes of these referrals, including the specific action these agencies took. Given the initial stages of ORT program implementation and the length of time it takes to resolve a complaint, call volume and resolution figures may not be high.

APPENDIX C

Definitions (Continued)

Building partnerships: The ORT legislation calls for developing partnerships with other state and local agencies and organizations responsible for combating health care fraud and abuse. The purpose of these partnerships is to provide for a logical link between ORT grantee activities and the work of other entities, including those that receive and investigate complaints. Please identify the agencies and organizations you have contacted and the results of your partnership-building activity during the reporting period.

Staffing and management: ORT grantees vary in how they allocate their funds among the State Unit, Area Agencies, and others responsible for program implementation and operation. In addition, many grantees are using the ORT award as seed money to stimulate the use of other resources to promote identification and reporting of health care fraud and abuse. Identifying the number of staff and volunteers engaged in ORT activity, beyond the limits of the grant, helps demonstrate the extent to which ORT funds have leveraged other resources.

APPENDIX D

Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

JUL 19 1999

IG ✓
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Date Sent 7/20/99

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Aging

SUBJECT: Comments to the Draft OIG Report OEI-02-99-00110, entitled, *Administration on Aging's Health Care Fraud and Abuse Programs: 18-Month Outcomes.*

I am writing to provide comments to the draft report of the Office of Inspector General (OIG) entitled, *Administration on Aging's Health Care Fraud and Abuse Programs: 18-Month Outcomes.*

The Administration on Aging is very appreciative of the valuable assistance provided by the OIG in developing performance measures for these projects and for your office's ongoing assistance in providing guidance on effective practices and common problems pertaining to the projects' efforts to train aging network staff and retired volunteers about health care waste, fraud, and abuse.

As you are aware, we operate two distinct sets of projects for this purpose. The first program is focused at the local level to train retired professionals who serve in their communities as volunteer expert resources and educators in combating health care waste, fraud, and abuse. The second is focused at the state level to train staff and professionals who provide services to older Americans and their families and develop new partnerships for establishing an effective statewide operational structure for identifying and reporting fraud and abuse.

The report provides a good overview of the distinctions and initial outcomes of these two programs and gives insight on the wide variation occurring among the approaches taken during this initial start-up phase. It is for this reason that we requested the study which is contained in your companion report, OEI-02-99-00111, *Implementation of the Administration on Aging's Health Care Fraud and Abuse Programs.* This information will provide us the opportunity to provide effective guidance on best practice strategies and enable projects to learn from one another.

We agree that specific dollar savings from the activities initiated by these projects is very difficult to track and we are working with your office to improve this tracking and reporting system. However, we believe it is also important for the report to note that the kind of training provided through these projects will result in a long-term investment whose total returns will not be known for years. The thousands of aging network staff who have been trained so far through

the one set of projects will in turn serve hundreds of thousands of beneficiaries throughout their professional careers. And the tens of thousands of beneficiaries who have been educated about calling their health care providers if they have questions about their bills can also be expected to lead to a general climate in which providers will bill more carefully. The fact that improper Medicare payments to hospitals and other health care providers have been reduced by 45% over the past two years indicates that this effort may be paying off dramatically.

We also believe that these efforts to educate and train aging network personnel and Medicare beneficiaries is critical for empowering beneficiaries and improving quality of care.

We at the Administration on Aging have enjoyed the close working relationship with the staff of the OIG and look forward to continuing to build an effective partnership to combat waste, fraud and abuse in the Medicare and Medicaid programs.

Jeanette C. Takamura